Strategies for the Future

The Division of Developmental Disabilities

Long-Range Plan Report
Phase 1: 1999-2001

Planning for the Services and Supports Needed by People with Developmental Disabilities and Their Families in Washington State

DECEMBER 1, 1998

Washington State
DEPARTMENT OF SOCIAL & HEALTH SERVICES

Acknowledgments

The Division of Developmental Disabilities (DDD) wishes to acknowledge contributions of the DDD Strategies for the Future Stakeholder Workgroup in the preparation of *The Strategies for the Future Long-Range Plan*.

The 18 members of the Stakeholder Workgroup have been working in conjunction with the Division since June 1997. They volunteered 20-30 hours per month in their commitment to build better supports for people with developmental disabilities and their families. They selflessly participated in countless hours of issue mediation, research reviews, and consensus-building with the various organizations and individuals that represent the disability community. Without their leadership and perseverance, this planning effort could not go forward.

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Long-Range Plan Report
Phase 1: 1999-2001

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SUBMITTED TO THE

WASHINGTON STATE LEGISLATURE

DECEMBER 1, 1998

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SERVICES

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Strategies for the Future Long-Range Plan

Executive Summary

The community service system in Washington for people with development disabilities and their families, funded through the Division of Developmental Disabilities (DDD), is eroding. It is reaching the point where ensuring health and safety of those dependent on the system is becoming uncertain.

In 1998, Governor Gary Locke and the Washington State Legislature recognized this growing crisis faced by people with developmental disabilities and their families and responded with two important actions:

- Passed a significant supplemental budget appropriation, allowing the Division to begin addressing the needs of those in deepest crises; and
- Unanimously passed SSB-6751, intended to stabilize long term care services for people with developmental disabilities and their families.

SSB-6751 directed the Division, in conjunction with the Strategies for the Future Stakeholder Workgroup, to make recommendations to the Legislature on how to best meet the needs of people with developmental disabilities and their families, today and in the future, addressing the following questions:

- how many people are in need of services?
- what services are needed?
- what do these services cost?
- what is the best way to address these needs?

This report, the Strategies for the Future Long-Range Plan, presents Phase I of a three-phase, three biennium planning project. There are two main strategies:

1) Stabilize current services through the next biennium to protect health and safety; and

2) Strategically plan to restructure the service delivery system to better meet individual and family needs in the most cost effective manner.

Nationally, Washington State ranked 39th (1996 data) among all states in the proportion of its total statewide personal income devoted to financing developmental disabilities services. Even with the new dollars received in the 1998 Supplemental Budget, Washington's ranking has only minimally changed. People with developmental disabilities and their families continue to face real challenges. Data indicates:

- DDD's caseload is growing by at least 7%, or about 1,500 people a year who are waiting for services;
- DDD caseloads have grown by more than 65% since 1992, to about 28,000 people;
- DDD's funding has only grown by 24% over the same period, increasing numbers of unserved people;

DDD caseloads have grown by more than 65% since 1992, to about 28,000 people.

The case management system has 2 1/2 times more consumers per case manager than the national average, ranking Washington last.

- A 30% decline in average expenditures per person served since 1992, goes well beyond recognized program efficiencies and compromises service quality;
- Community provider staff retention and service stability suffers from underfunding; and
- The case management system has 2 1/2 times more consumers per case manager than the national average, ranking Washington last.

The lack of available resources is most clearly evident in the magnitude of "unmet needs". The Division calculates that 9,000 people will need additional services in the 1999-2001 biennium. Services needed include residential placements for 4,505 people; employment services, day programs, or early intervention services for 2,928 children and adults; individual and family supports for 3,969 people and their families.

This is only a partial solution in meeting the total increased costs to provide the service and support needs of all the FY2001 caseload, which exceeds $262.6 million General Fund - State dollars ($447 million total). To ensure the health and safety of people on the Division's caseload and to begin service delivery stabilization, the Division and the Stakeholder Workgroup recommend an increase of $88.9 million General Fund - State dollars ($148.1 million) in the 1999-2001 biennium.

The Division and the Stakeholder Workgroup are developing recommendations on future directions and strategies to improve service delivery - restructuring the service system. These recommendations will be delivered to the Legislature on December 1, 2000 as part of Phase II of the Strategies for the Future Long-Range Plan.

Introduction

This report, *Strategies for the Future Long-Term Plan – Phase I*, describes the current challenges faced by Washington State's service system for people with developmental disabilities. It presents analysis and information required by SSB-6751 (C 216 L 98), "AN ACT Relating to stabilizing long-term care for persons with developmental disabilities living in the community and in residential habilitation centers," signed into law in March 1998. In Section 7 of the Act, the Department of Social and Health Services is directed to:

- determine whether persons with DD are served, unserved, or underserved
- gather data on the services and supports required by this population, their families or their guardians
- determine the cost of providing these services
- develop a long-term strategic plan with the participation of the Stakeholder Workgroup
- include three phases - December 1, 1998, December 1, 2000, and December 1, 2002
- include incremental data and assessment of programs, services, and funding
- include budget and statutory recommendations intended to secure for all persons with developmental disabilities the opportunity to choose where they live."

The Division of Developmental Disabilities (DDD) is chartered to provide needed support to people with developmental disabilities and their families. These services and supports include assistance in education, life skills, physical accommodation, employment, and living arrangements. A full spectrum of long term care services is provided for people with developmental disabilities and their families. People are partners in the design of these supports to ensure that their needs are met effectively and efficiently.

Our state has a history of providing the supports necessary for all of our citizens to thrive and contribute. People with developmental disabilities and their families share in our diverse heritage and in the need for basic supports to help them fully contribute to Washington's quality of life. But although Washington is nationally recognized for having one of the top aging long-term care systems for the general population, our state compares unfavorably in the reach of its long-term support system for people with developmental disabilities.

This report - part of the Phase I work directed by the 1998 law - is a strategic plan outlining the critical needs and issues in Washington's service system for people with developmental disabilities and proposing durable solutions for state decision makers to consider.

This plan is organized as follows:

- **Chapter 1** identifies historical and current critical issues.

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• **Chapter 2** describes unmet service and delivery needs and their estimated aggregate cost. Unmet needs are defined in terms of five major support functions: Services, Essential Case/Resource Management, Assuring Service Quality & Accountability, Community Provider Stabilization, and Administrative Supports.

• **Chapter 3** provides a method for prioritizing critical service and delivery needs and makes funding and/or policy recommendations to begin addressing the identified critical needs.

• **Chapter 4** presents the Division's planning strategy for restructuring the service delivery system to enhance consumer satisfaction and resource management. Pilot projects to test new strategies will likely begin in earnest during the second half of Phase I (FY2000).

• **Chapter 5** describes what is anticipated for Phase II and III. Each of the last two phases will incorporate the experiences of pilot projects, new research findings, and unmet need data updates.

• The **Appendices** contain an informational guide to the Division and in-depth summaries of the research investigations used to identify and measure the unmet and undermet needs of people eligible for Division services and supports.

Chapter 1 Overview of Funding and Services

SECTION 1: Fiscal Effort: Washington State Compared with Other States

In Washington, $2.92 of every $1,000 of total personal income was spent in developmental disabilities services, while the national average was $3.64.

Making reliable comparisons of funding and service levels between states are notoriously difficult. Getting consistent, accurate data is a daunting task. Even more troubling, states do not provide services under the same administrative structures. It is easy to make incorrect comparisons of state organizations that have similar titles, but that are in reality significantly different.

Fortunately, state to state comparisons between developmental disabilities programs are more viable than those between most state human service programs, although caution must still be used. The American Association on Mental Retardation has financed a 16-year research effort collecting and analyzing state developmental disabilities funding and service, conducted at the University of Illinois, Chicago, by David Braddock and his associates. The fifth edition of *The State of the States in Developmental Disabilities*, published earlier this year, contains data from 1977 through 1996 (Braddock et al., 1998).

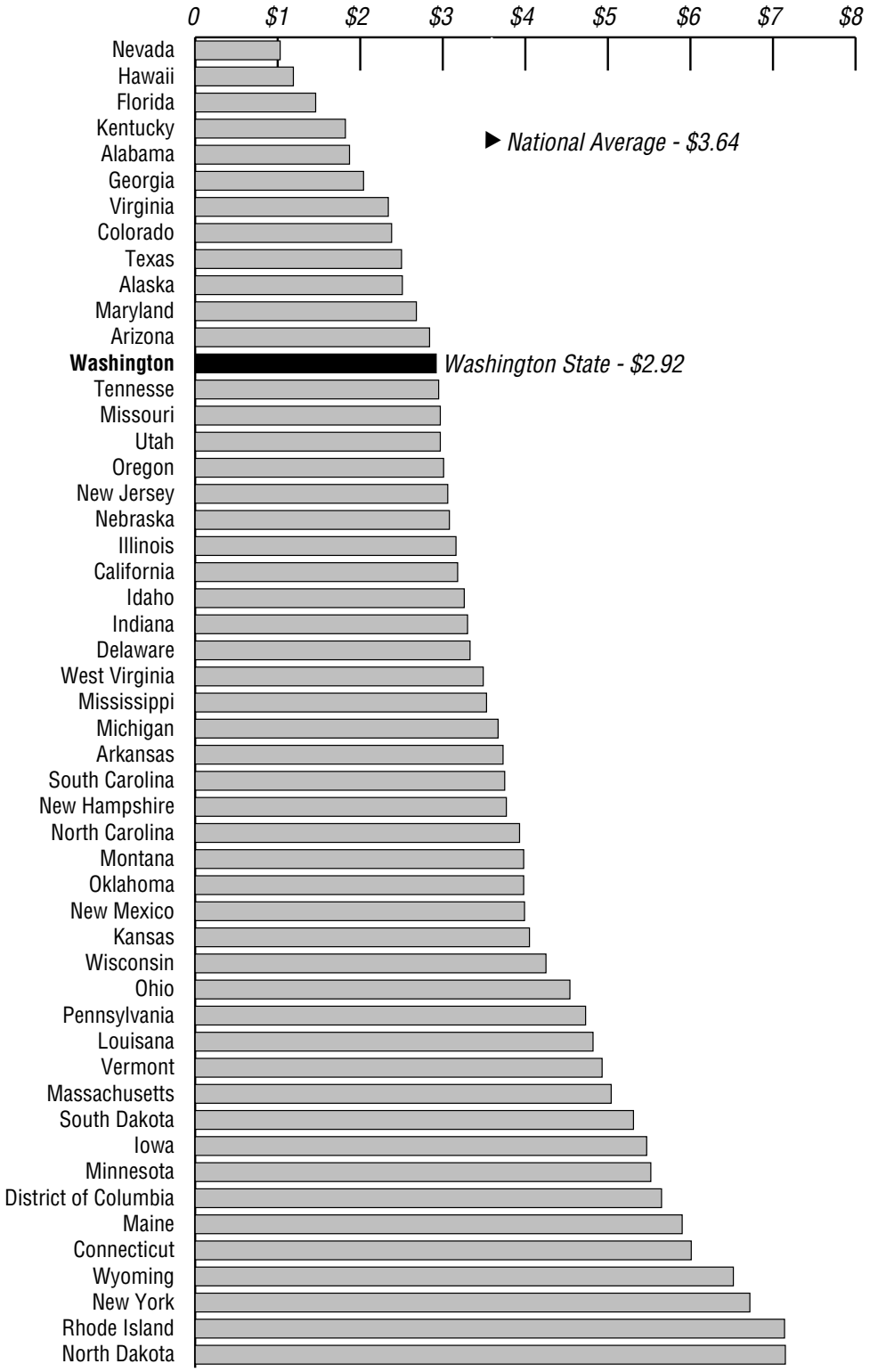
Perhaps the key comparison found in this report is a Fiscal Effort Ranking. The researchers compare states on the proportion of total statewide personal income devoted to the financing of developmental disabilities services. This index allows large states to be contrasted equitably to smaller ones, or wealthy states to poorer ones. Washington State is typical in the types of services its state developmental disabilities programs operates. Figure 1 shows that Washington ranked 39th of the 51 states in 1996 (including the District of Columbia). In Washington, $2.92 of every $1,000 of total personal income was spent in developmental disabilities services, while the national average was $3.64. In 1996 dollars, it would take a 25% increase in annual expenditures in Washington for it to equal the national average, an approximate increase of $97.1 million ($194.2 million for the biennium).

In 1998, the Washington Legislature gave the Division of Developmental Disabilities a significant supplemental budget appropriation of $45.4 million. (This figure excludes the transfer of provider rate increases and children's voluntary placement program into the Division's budget.) Although this infusion may have raised Washington State's ranking, other states have also increased their funding for DD services since 1996. California's Division of Developmental Disabilities received a supplemental budget increase of $227 million in 1998, for example. In terms of 1996 dollars, Washington may have increased its relative ranking somewhat, but it still likely falls significantly below the national mean.

Probably most Washingtonians would be surprised to learn that our state ranked so poorly in funding services for persons with developmental disabilities in 1996. This is not a recent trend, however, as Washington has never ranked above 32nd since the Braddock study began in 1977; the cumulative overall average ranking is 37th.

Given that Washington is in the bottom third or quarter of states in fiscal effort, great pressure is put on families of persons with developmental disabilities and on the Division to provide services comparable to other states.

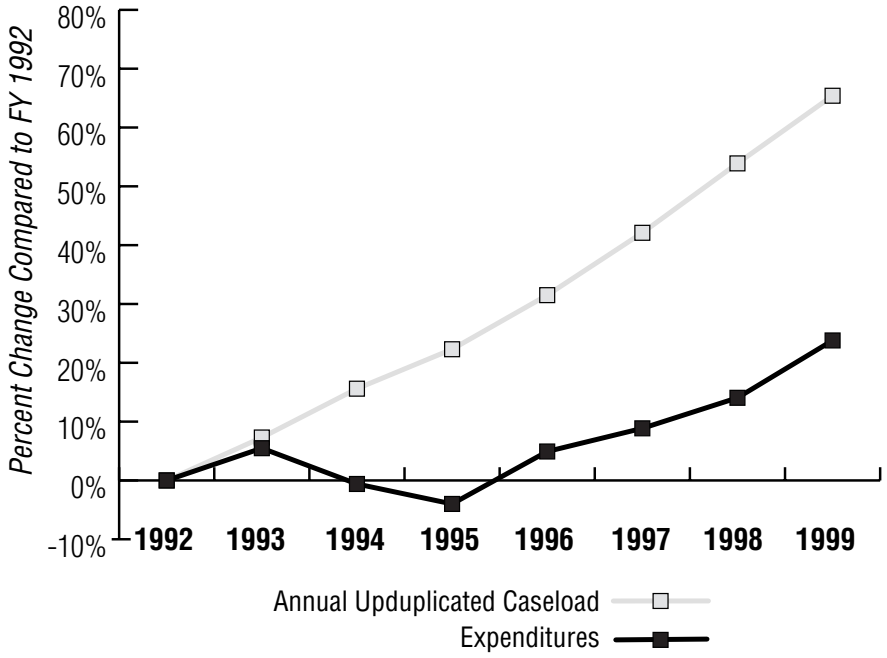
Figure 1: State Spending on Developmental Disabilities Total Fiscal Effort



SECTION 2: Recent Caseload and Funding Trends

In the last decade, the caseload of eligible persons with developmental disabilities who sought services from DDD has grown at an average annual rate of 7%, or about 1,500 persons a year. The top line in Figure 2 shows the caseload increase from 1992 through 1997 and estimated to 1999, an increase of more than 65%. The data presented in Figure 2 are based on an unduplicated annual count; monthly averages tend to underestimate the number of persons actually served.

Figure 2: Percent Change in Caseload and Expenditures for the Division of Developmental Disabilities from FY92 through FY99
Expenditures include FY98/99 Supplemental
(Adusted for inflation, excludes IMR tax)



Why has the caseload grown at such a high rate? First and foremost is that the DDD is still reaching out to all those eligible and needing assistance. The population of persons with developmental disabilities in the general population of Washington State probably is between 105,000 and 170,000 (see Research and Data Analysis technical report #5-24). In fiscal 1998, the eligible sub-population of 28,000 is only a quarter to a fifth of the overall population of persons with developmental disabilities in the state.

During the 1990s, the identification and referral of persons with developmental disabilities has been greatly strengthened by the federally funded Birth-to-Six program, now known as the Infant/Toddler Early Intervention Program (ITEIP). This program identifies the lower income and minority children that DDD has historically missed. Another major reason for the growth is that more persons with developmental disabilities are surviving through early childhood and more persons are living longer.

The bottom line in Figure 2 shows the growth in DDD's expenditures, adjusted for inflation. From 1992 to 1997, the increase was minimal, less than 9% in real dollar terms. The

1998 Legislature, in response to a supplemental budget request of Governor Locke, appropriated a substantial increase, raising inflation-adjusted funding to nearly 24% above the 1992 level. The legislature responded to each of the identified "potholes" in DDD's budget, providing substantial relief for those persons with developmental disabilities and their families who were in the deepest crises.

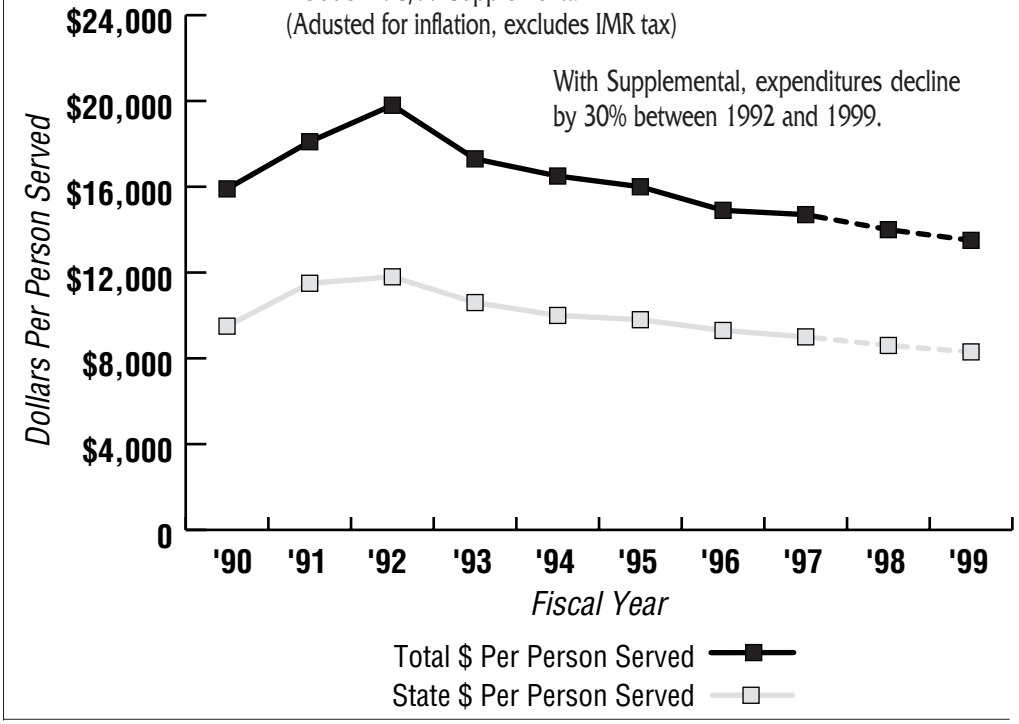
However, the gap between caseload growth and funding growth continues to widen. Next biennium, the caseload growth is expected to eclipse the 7% average annual rate experienced in 1992-97. It would take a 14% increase (beyond the maintenance level budget) just to keep even with the caseload.

SECTION 3: The Service Picture During the 1990s

How has DDD responded to the flood of additional persons to be served with only limited additional funding? Figure 3 gives the overall answer. The Division has continued to serve more and more persons, with a resulting 30% decline in average expenditures per person. This has been accomplished by adding only modest increases in residential services. The Division has relied heavily on adult family homes (AFH), a relatively inexpensive residential program with minimal personal supports, to meet the increasing need for out-of-home support. It has placed even more emphasis on the use of in-home supports through the Medicaid Personal Care (MPC) and family support programs. The recent development of a new form of family support, which has reduced average costs, promises to serve up to 1,800 families from the waiting lists without additional funding.

The Division has relied heavily on adult family homes (AFH), a relatively inexpensive residential program with minimal personal supports, to meet the increasing need for out-of-home support.

Figure 3: DDD Ratio of Expenditures to Persons Served



The increased use of more limited and less expensive services has only partially filled the funding gap. Some service needs are inherently expensive and are thus left unaddressed. A recent bright spot was the 1998 supplemental budget increase that allowed some persons with intensive support needs, such as expensive community protection issues, mental health and/or behavioral challenges, access to new residential services. Helpful as this was, the funding increases only began to address the needs of people with developmental disabilities seeking services from the Division as caseload pressures continue to increase.

SECTION 4: The Problem of Case Management

The National Association of State Developmental Disabilities Directors conducted a survey of states' developmental disabilities programs for 1996. This survey looked at the ratio of case managers to persons with developmental disabilities on caseloads. The results in Figure 4 show a truly shocking state of affairs for the State of Washington. Of the 42 states that responded, Washington ranks last. Our ratio is 175 consumers for each case manager, based on eligible persons. Since most states count as clients only those eligible persons who also received a service during the year, our count should be adjusted to 125 to 1. In 1979, the Division operated with a caseload ratio of 78 to 1. In 1997, that ratio had eroded to about 141 to 1, based on caseload growth. No matter how you look at it, Washington still ranks last at more than 2.5 times the average national ratio of 40 to 1.

There probably is no feature of Washington State's DDD service system that ranks further below the national expectation than case management. With the excessive caseload ratios in the '90s, the Division has not had sufficient staff to maintain minimal expectations, even with the strenuous, excellent efforts put forth by the case managers themselves. Caseload increases have just not been matched by corresponding increases in case managers.

In addition to the tremendous growth in the caseload ratios, the complexity of the case manager's role has also increased dramatically. Case managers have shouldered the additional burden as the state has increased its participation in federal programs. The variety and intensity of community-based services has also placed additional demands on case management staff. The demands Washington places on its case management staff is more than three times the national median!

The legislature did fund a small increase in case managers in the 1998 supplemental budget request. The increased funds will assist the Division in maintaining the documentation required to meet federal funding requirements. Sufficient staffing to ensure the health and safety of eligible people in need of services has not yet been addressed.

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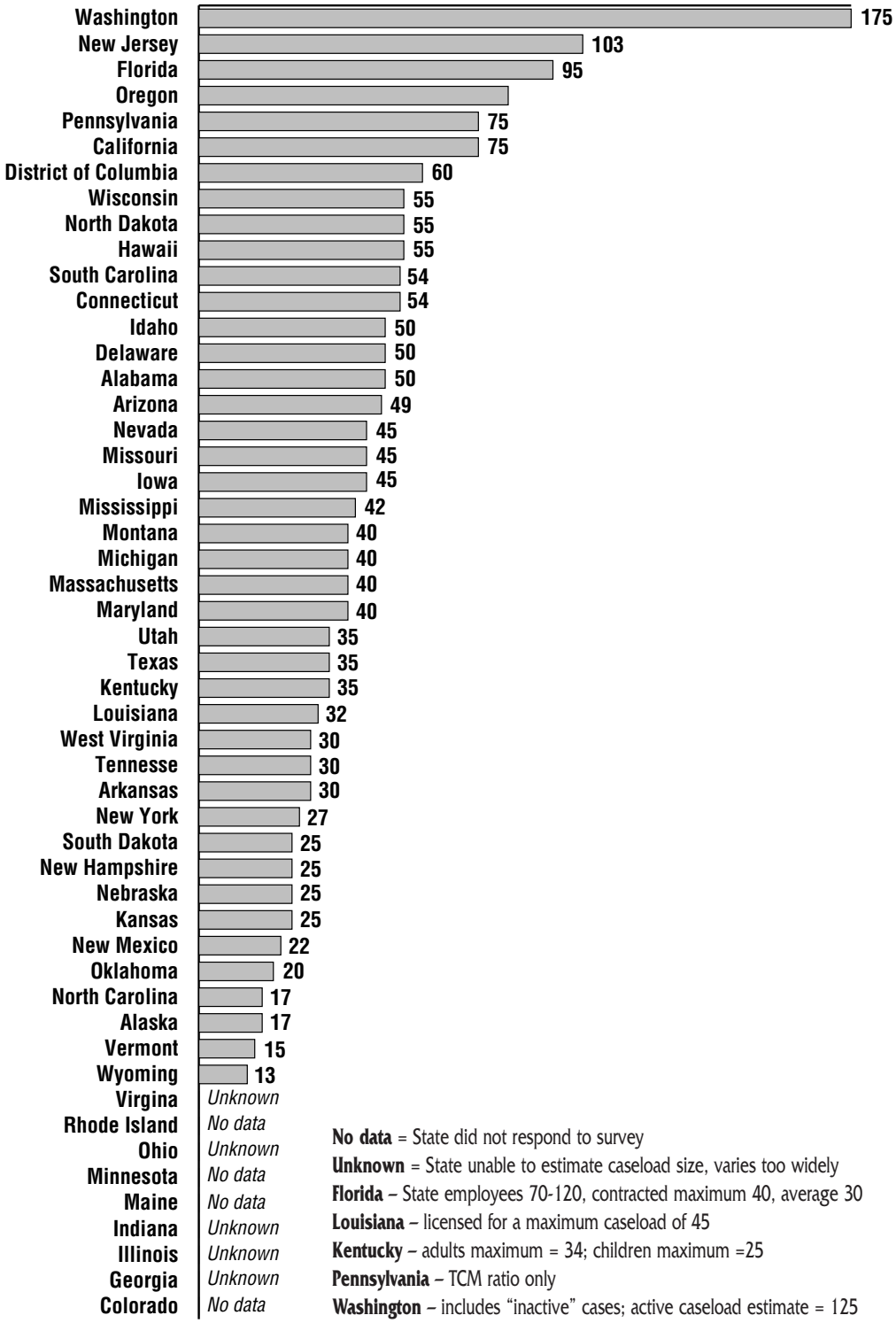
Of the 42 states that responded to the survey, Washington ranks last. Our ratio is 175 consumers for each case manager, based on eligible persons.

Figure 4: Developmental Disabilities Caseload* Ratios, FY96
(1996 NASDDDS Survey)



SECTION 5: What is the Next Step?

The overall picture for Washington State's services and supports for persons with developmental disabilities holds both promise and serious concern. Historically, Washington has not devoted the fiscal effort to DDD as have most other states. Caseload continues to grow rapidly and, except for the welcome funding of the 1998 supplemental budget, funding has lagged behind. Already, major efforts have been expended to lower costs and operate more efficiently; more efforts are planned. The lack of case managers has become critical. So, what is the next step?

Before proceeding, it is necessary to assess critically what is the true "unmet need" of people eligible for the Division's services and how the Division can more effectively meet and manage these needs. This is what the Legislature directed in SSB 6751. The remainder of this report will assess our service needs and system weaknesses, provide an estimate of what it will cost to meet these unmet needs, and discuss how we will plan for the future.

Chapter 2 Determining Unmet Needs

SECTION 1: Unmet Service Needs

Determining the unmet needs of people eligible for Division services, and the cost to meet those needs, represents a formidable undertaking. In January 1998, the Division began a study of service need data of the "unserved" and "underserved" on the Division's caseload, as well as the needs of those projected to enter our caseload in the coming biennium. DDD also studied the essential work of the case/resource management system, including issues of provider stabilization, quality assurance, and management information systems, to estimate the total cost of providing services.

Ralph's story

Ralph is 55 years old and has always lived with his parents. A year ago his father had a stroke and was admitted to a nursing home; a month ago his mother was diagnosed with cancer and began chemotherapy. His mother has contacted DDD to ask for in-home supports, but the family has never applied to DDD before and Ralph is placed on a waiting list for family support and for vocational support. Both he and his mother want him to remain at home.

The Division maintains a database to track unmet service needs throughout the DDD caseload. Several problems have surfaced relating to the accuracy and completeness of the unmet needs database. It does not record service needs information for people who don't express a need for services, such as those with community protection issues. Data are incomplete and/or inconsistent for students graduating from high school and seeking services and for people completing the DDD eligibility process before they seek services. Also only a fourth to a fifth of the state's eligible population are known to the Division (see RDA technical report #5-24).

After updating the unmet needs database, correcting for errors, and estimating the number of new eligible enrollees, the Division expects that, in the next biennium, there will be nearly 9,000 people needing services that are currently unavailable. These service needs are estimated to fall in the following areas:

- 4,505 people will need new residential placement services; 519 of these are deemed "high cost" services.
- 2,928 people will need employment services or day programs; 495 of these are deemed "high cost" services.
- 3,969 people will need family support, personal or attendant care, or therapy services; 2,465 of these are deemed "high cost" services.

(Note: These above numbers represent service needs. The Division's services are

described in greater detail in the Information Guide, located in Appendix A; people with different types of needs may be counted in more than one category; fuller details on how unmet needs were defined and verified can be found in the unmet needs study by Research and Data Analysis (RDA) included in Appendix B.)

The anticipated cost to meet anticipated needs of all the FY2001 caseload exceeds $287 million, up from $174 million to address the unmet need from FY1997. This figure includes several elements: direct costs for providing services; resource development and start-up (to place a person into the needed service); ongoing case management; county administration (if any); and staff training. (Also included are the provider stabilization increases recommended in Strategy 1, Chapter 3.)

SECTION 2: Essential Case and Resource Management

Case management is the vehicle that brings people and services together. In Washington's service system, case and resource management functions are generally combined and performed by one individual. To understand the role of case and resource management and the need for appropriate caseload ratios, the Division conducted a Workload Study in 1997. The study endeavored to develop workload standards, to determine the time necessary to accomplish these tasks, to understand and account for complex characteristics and circumstances of individuals currently on the caseload, and to develop a system to project caseload growth and the staffing necessary to accommodate it. (For a summary of the complete Workload Study and the methods to accomplish these four objectives, see Appendix C or RDA's technical report #5.30A).

Figure 5 shows that under the caseload conditions present in 1997, only 51% of the case manager's caseload received direct contact, 21% had indirect contact, and 28% had no contact during the year. Caseload growth has reached levels more than twice the national average, and it has occurred without a corresponding increase in case/resource management staff.

Figure 5: Case Manager Contact with Individuals in Caseload
(1996 NASDDDS Survey)

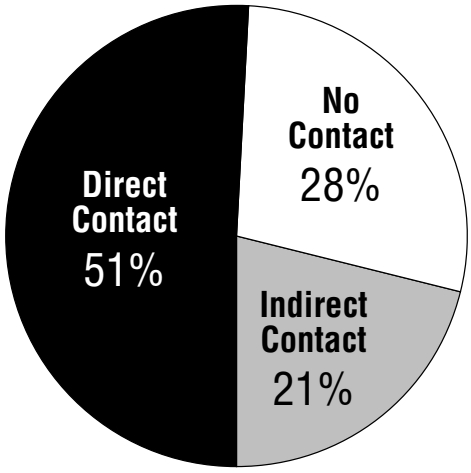


Figure 6 shows that case/resource managers had time to do only 45 percent of their essential functions on behalf of the people they served: caseload member contact, case management (including connecting people to resources, monitoring service quality, and reviewing service appropriateness), resource management, intake and eligibility reviews, and other support services. Based on 1997 data, Figure 6 includes estimates of the additional staff needed to maintain workload standards and complete the 55 percent of the essential work not being done. To the current 170 case/resource managers, an additional 198 are needed to complete essential functions relative to the current caseload.

Figure 6: 1997 FTE Gap

Work Activity	Percent of Essential Work Not Done	Actual FTEs	Extra FTEs
Review persons on caseload who have not been contacted	100%	0	22.4
Case Management			
Connecting persons to adequate supports/services	38%	39.6	26.7
Monitoring supports/services to ensure quality	64%	51.7	87.5
Reviewing match between clients and supports/services	67%	13.7	28.1
Resource Management			
Developing and maintaining resources	33%	43.7	21.5
Intake and Eligibility Review	48%	12.8	11.7
Other supports**	not available	8.3	not available
TOTAL	**55%**	**169.8**	**197.9**

*Note: Reviews are required by federal and state mandates. Not meeting these reviews creates major problems regarding compliance.

**Such as Child Development services, School-related services, DCFS supports

Figure 7 reveals the unmet case management need for the anticipated FY2001 caseload. Case management staff includes case managers, resource managers, supervisors, clerical staff, accountants, and support specialists.

Figure 7: Unmet Case Management Need for Anticipated FY2001 Caseload

Case Management Need	1997 Gap (for 24,000 clients)		1997-2001 Increase (for 33,550 clients)		Total Extra Needed by 2001	
	Extra FTEs Needed	Cost	Extra FTEs Needed	Cost	Extra FTEs Needed	Cost
Unseen Clients	22.4	$1,531,460	9.0	$615,141	31.4	$2,146,601
Case Management	142.3	$9,727,350	37.6	$2,569,922	179.9	$12,297,272
Resource Management	21.5	$1,468,300	0.0	$0	21.5	$1,468,300
Intake and Eligibility Reviews	11.7	$801,996	9.0	$615,141	20.7	$1,417,137
Case/Resource Manage. Total	**197.9**	**$13,529,106**	**56.0**	**$3,800,204**	**253.9**	**$17,329,310**
Supervisors+Admin. Support**	56.5	$3,561,045	13.0	$784,976	69.5	$4,346,020
Total FTEs and Annual Costs	**254.5**	**$17,090,150**	**69.0**	**$4,585,180**	**325.5**	**$21,675,330**

**Note: Administrative support includes clerical, information support specialists and accountants. Ratios are: supervisors 1:8, clerical support 1:10, + 6 information support specialists and 6 accountants.

The Division estimates that 198 new case/resource managers and 56 related support staff are needed to perform essential workload standards according to 1997 data. An additional 56 case/resource managers and 13 related support staff are needed to manage the expected caseload growth from 1997 to 2001. This totals 254 case/resource managers and 69 related support staff at a biennial cost of approximately $21.7 million. Current eligible persons and their families, as well as the 1,500 new people added to the caseload each year, will not access adequate services without a corresponding investment in the essential functions of case management.

SECTION 3: Assuring Service Quality and Accountability

Quality Assurance is vital to ensuring the health and safety of individuals served by DDD. The Division is facing several quality assurance issues that threaten service integrity and personal safety. A summary of these issues follows.

1. Provider Compliance

The Division contracts with more than 140 private residential service agencies, 39 counties for contracted employment and day programs, and 12,000 private individuals who provide personal, respite, alternative living, and attendant care. These providers deliver support to more than 17,000 people on the Division's caseload. DDD has a formal, although not uniform, process to assess provider compliance for residential, employment, and day program services. The Division contracts with outside professionals to evaluate providers of residential services at least once every two years. Division field services staff address deficiencies. County personnel are required to evaluate employment and day program providers.

The Division does not routinely evaluate individual providers of personal care services, however. Division staff do not know whether clients receiving services from these providers are satisfied with the service, whether the provider is delivering the requested service, or if the service was performed adequately. This problem will be additionally compounded by the Division's plans to expand the use of contracted individual providers. To respond to this challenge, the Division proposes to develop service quality teams within each region. These teams would be responsible to:

- Perform annual surveys of individual providers, families, and persons receiving in-home services and provide follow-up on any corrective action.
- Perform random home visits to assess individual provider work performance.
- Perform annual adult family home site visits for those serving people on the Division's caseload.
- Provide follow-up on plans of correction for all residential agencies.
- Re-certify residential providers.

■ Work with county coordinators to assure service quality and employment/day program contract compliance.

■ Coordinate with case/resource managers on any provider corrective action.

■ Develop guidelines and a statewide process for performing quality assurance functions in a uniform manner.

■ Coordinate training to help individuals and families make informed service and provider choices.

■ Deliver and coordinate all provider staff training.

Service quality teams would be organizationally aligned to ensure separation and autonomy from the field service delivery system. Each team would consist of four members, one existing staff and three new. The new staff would primarily be responsible to develop and implement the new survey and site visit process to evaluate the region's contracts with individuals providing personal, respite and attendant care. The biennial cost of adding these 18 staff (12 case/resource managers and 6 office assistants) is $2.1 million.

2. Provider Staff Training

Residential, employment, and day program providers employ approximately 6,100 full and part-time staff to deliver services to people on the Division's caseload. Another 1,000 individual providers provide alternative living and attendant care services. Recent survey data, discussed in the following section, indicate that staff turnover in these agencies is extensive. As many as 3,500 new staff are hired each year and need core training to ensure the health and safety of the people being served by their programs. The Washington Administrative Code (WAC) requires that all new staff receive at least 32 hours of training. Continuing training and education is needed to ensure adequate care and safety for persons receiving services. The Division also expects providers to have the skills to support people with increasingly complex needs, such as people with mental health or community protection issues.

To address the training needs of new provider staff, a minimum of 38 hours of core training is required to prepare each person to provide the necessary supports needed by an individual with developmental disabilities. For current provider staff, a minimum of 12 hours of continuing education per year is required to maintain essential skill levels. Assuming a 33 % annual provider staff turnover, and the need to provide replacement staff while the provider staff are being trained, the biennial cost to provide core training and continuing education to the estimated 7,100 provider staff is $6.2 million.

3. Residential Evaluator Rate Increase

The rates DDD pays to the professionals with whom it contracts to evaluate its residential programs have not increased in the last decade and are no longer competitive. To

ensure the quality of the current evaluation process and continued provider compliance, the Division must increase rates for these evaluations. Increasing the contract rates by 20% for evaluating the current 142 agencies providing residential services would cost $85,000 per biennium.

SECTION 4: Community Provider Stabilization

High staff turnover and difficulty in recruiting staff are pervasive problems found in all three systems serving individuals in the community: residential programs, county/day programs, and personal care services. These problems have reached critical levels, particularly in urban areas where low unemployment, high cost of living, and competition from other employers create an extremely competitive environment. The Division has worked with consumers and service providers to verify and analyze the problem and to develop an approach for addressing the cause and impacts associated with the staff retention deficits. Key findings follow.

1. Residential Providers

In December 1997, 79% of all community residential providers statewide responded to a DDD survey circulated by the Division that asked about hours, rates, turnover, and time needed to replace staff. The providers indicated pervasive problems which were confirmed with an additional survey in May 1998. The surveys found that statewide, direct care staff annual turnover rates averaged 48%. With the highest rates in the urban counties. The average direct care staff wage was $7.52 an hour. Of providers surveyed, 90% reported difficulty hiring staff and 78% reported difficulty keeping staff, primarily because wages are inadequate given expectations of the jobs and competition from other employers.

In 1990, the Legislature attempted to stabilize wages paid to residential providers by linking them to wages paid to care staff in private residential settings. Since 1990, wages have fallen far behind this policy. The current benchmark of $12.61 per hour needs to be raised to $14.62 an hour to be consistent with stated policy. The Division also proposes to adjust the benchmark further to recognize geographic cost-of-living differences. Following logic used by the state Aging and Adult Services Administration and the Department of Economic Security, cost-of-living differences can be addressed by establishing a higher staff rate for metropolitan and more urban counties. These include Pierce, Snohomish, Spokane, Clark, Kitsap, Thurston, Benton, Franklin, Yakima, and Whatcom counties. The benchmark for staff working in King County would be at a higher incremental step, consistent with the findings of the 1997 residential survey.

The biennial cost is $44 million to raise the benchmark to $14.62 per hour for all residential staff working in non-metropolitan counties, 5% higher to $15.35 in metropolitan counties, and an additional 5% to $16.08 in King County.

2. County/Day Programs

The county/day programs are also a focus of concern. These programs were surveyed in the summer of 1998. Preliminary results indicate an average staff turnover for adult programs of about 40%, that about half of the programs encounter difficulty keeping and hiring staff, and across program, from 56% to 88% of positions are vacant for more than 21 days.

Due to the complexity and variation of the county/day program provider reimbursement methods, it is difficult to identify a solution or the amount of resources that would be required to reduce day program staff turnover. Additional day program provider staff salary information is needed to analyze and understand the issue fully.

As a first step to addressing the problem of staff turnover, the Division recommends a 5% increase in direct care staff salaries, at an estimated cost of $3.3 million.

Kristyn's story

Kristyn has a 10 year old daughter with disabilities. Over the past seven years, the family has qualified for respite services. "In that time, we've had seven providers who have lasted an average of three days," says Kristyn. "Even though intellectually I know I shouldn't, emotionally I have given up. Over the past four years when I was a fulltime student, I missed classes because the respite person simply didn't show up. Providers need to receive more intensive training and they must be paid a higher wage, commensurate with the work they are expected to perform."

3. Individual Providers

Individual providers hold contracts to provide personal, respite, and attendant care to persons with developmental disabilities and their families. Consistently, families and case managers have reported that it is difficult to find and retain qualified providers. Consequently, families are using only 80% of their allocated funds. Anecdotal evidence suggests that there is at least an annual 50% individual provider staff turnover.

The wage currently paid these providers is $6.18 per hour, plus FICA and FEMA. A statewide consensus that this wage is too low is developing among agencies which use personal care providers, including the Aging & Adult Services Administration. The Home Care Association recently proposed and supported legislation to increase the rate to $8.50 per hour. The biennial cost of this rate increase, just for those providing services to people on the Division's caseload, is about $42 million.

4. Adult Family Homes

Approximately 1,120 people on the Division's caseload currently reside in adult family homes. Most of these people are able to benefit from the reduced level of supports

(compared with most other Division residential services) available in AFHs. These homes are used even more extensively by the Aging and Adult Services Administration. The Division pays AFH providers about $600 less per month than does Aging and Adult Services. As a result, AFH are migrating away from serving the Division's clients as the demand for placement in the Aging and Adult Services continues to grow.

In order to continue to have these cost-effective residential supports available to the Division's caseload in the next biennium, $16 million is needed to increase the Division's rates to that of Aging and Adult Services.

SECTION 5: Administrative Supports

The Division is currently operating more than $900 million worth of services biennially. Administrative staff and overhead has been greatly reduced over the last two decades, currently estimated at less than 3% of the Division's total appropriation.

A direct result of the minimal funding of administrative functions is a growing inability to manage the data necessary for program management, service delivery, and strategic planning. It is essential that the Division continues to conduct accurate needs assessments, purchase and maintain computers, support technical personnel, conduct mailings, perform network administration, etc., despite the cost burden these activities generate.

The Division is investing in new data tracking and management technology to aid in service administration and planning. The database tools currently in use are more than 12 years old and are highly inefficient. The Division recently began developing the Trends and Patterns Database to improve the Division's ability to evaluate aggregate client needs, particularly for clients that use services from multiple DSHS agencies and other government sources.

The Division has organized critical infrastructure needs into two general categories: caseload forecasting/needs assessment and critical information/data management. Proposed here for the next biennium is a project to enhance forecasting capability and improve individual planning. The first step is to test, on a sample of 2,000 from the DDD caseload, a new three-step assessment procedure that uses a nationally standardized form. Data from this sample would be used for improved Division-wide strategic planning and reporting purposes. The cost of implementing this new approach in the next biennium is $400,000.

To improve information/data management, several separate but connected information systems are needed in support of general budget requirements and strategic planning activities (particularly those associated with SSB-6751). The Division began investing in a "relational" database that would be able to cross-match various databases and information sources relative to the needs and characteristics of individual consumers. Quality Improvement projects are also in the design stages to improve information

accuracy and efficient retrieval. The Division is currently involved in major database transitions involving the MAPPER (Maintain, Prepare, and Produce Executive Reports), CCDB (Common Client Data Base), and CHRIS (County Human Resource Information Systems) systems. New or restructured databases are being developed to track persons with community protection issues, supported employment in government, residential choices, children aging out of Children's Administration services, those living at home with aging caregivers, and high school graduates seeking employment. The Division requires an additional 5 full-time staff to manage its core responsibilities, at a cost of $2.1 million over the next biennium.

SECTION 6: Summary of Unmet Needs

This chapter has developed a picture of the unmet needs of people eligible for Division services, both currently and projected through the next biennium. The following summary combines the cost information from the previous five unmet need sections.

Summary of Total Unmet Needs for the 1999-2001 Biennium

Need Category	Total funds	GF-State
Address Unmet Service Need	$287,000,000	$170,900,000
Increase Case/Resource Management	$43,400,000	$28,200,000
Assure Service Quality and Accountability	$8,400,000	$5,600,000
Stabilize Community Provider	$105,300,000	$56,200,000
Revise Identification of Unmet Service Need Process	$400,000	$300,000
Improve Administrative Supports	$2,100,000	$1,400,000
Total	**$446,600,000**	**$262,600,000**

(Note: These are the resources required to support people in programs, maintain case/resource managers, and increase provider rates for the full two years of the 1999-01 biennium.)

This analysis fulfills the first directive from SSB-6751: to assess needs and the costs associated with meeting these needs. SSB-6751 also requires the Division, in conjunction with the Stakeholder Workgroup, to provide budget and statutory recommendations as part of the strategic plan. In Chapter 3, we discuss how much of the unmet need should be addressed in the next biennium.

Chapter 3 Strategies to Reduce or Eliminate Unmet Needs

SECTION 1: Strategy 1 — Stabilizing the Current System

The Division and the Stakeholder Workgroup recommend two broad strategies to meet the critical needs faced by the people who depend on the Division for services and supports. The goal of Strategy 1 is to stabilize the current service system for all the Division's current caseload in the 1999-2001 biennium, providing some new services to unserved people with the most critical needs. This is the necessary first step to Strategy 2, the goal of which is to restructure the system to enhance choice and service effectiveness.

The budget recommendations for Strategy 1 are tempered by an analysis of the current system capacity. The Division reviewed historical service expansion periods where community service capacity was increased to accommodate people moving out of the RHCs, Intermediate Care Facilities for the Mentally Retarded (ICF/MRs), and nursing homes, as well as those transitioning from high school into employment. The Division also held discussions with contractors to consider their perspectives on how much could be attempted with quality results in a two-year period. Other variables were also considered, such as the effect of economic forces, rate stabilization, and staff capacity relative to current workload demands.

SSB-6751 also requires assessing services provided by the residential habilitation centers (RHCs). The Stakeholder Workgroup and the Division decided to focus on evaluating RHC capacity and needs as part of their Strategy 2 investigations, as discussed in Chapter 4.

The budget recommendations developed by the Division and the Stakeholder Workgroup in Strategy 1 are designed to stabilize current service availability and quality and to add new service consumers at a sustainable rate. Strategy 1 is a single proposal with interconnected recommendations – adjusting one affects all the others. All costs refer to the 1999-2001 biennium.

SECTION 2: Summary of Strategy 1 Budget Recommendations

The following funding recommendations and cost analysis were developed in conjunction with the Stakeholder Workgroup:

(The first figure given is total dollars and the second figure refers to General Fund-State (GF-S)dollars; the budget proposal's reference to the "high cost" and "low cost" unmet need categories is described in greater detail in the full unmet need study located in Appendix B.)

1. Unmet Service Need 1999-2001 biennial cost

The Division recommends that the following proposals be funded to address the critical needs of people in need of services:

Residential

Develop 250 new phased-in high cost resources $21,900,000 ($12,000,000 GF-S)

Develop 175 new phased-in low cost resources $4,400,000 ($ 2,500,000 GF-S)

- Provides high cost residential resources (including therapies) for an estimated 119 people in critical need of community protection services (level 1 community protection criteria), 48 people with mental health issues, 33 people living with aging caregivers, 25 people wishing to leave RHCs, and 25 people offered choice through SSB 6751.
- Provides low cost residential resources for an estimated 67 people living with aging caregivers, 24 people with mental health issues, and an additional 84 people.
- Includes resources for 11.5 case/resource managers and 2.5 support staff required to develop the new services, provider staff training, and an average 9.1% provider rate increase.

Employment/Day Programs

Expand and phase-in services for 425 unserved people to access new residential resources $ 3,600,000 ($ 3,000,000 GF-S)

- Provides day program resources for the 250 people who will receive high cost residential resources, and the 175 people who will receive low cost residential resources.
- Includes resources for 1 case/resource manager in the first year, adding a second case/resource manager in the second year.

Expand and phase-in resources for the young people transitioning from school $ 4,200,000 ($ 3,600,000 GF-S)

- Provide services to 350 students leaving school the first year of the next biennium and 375 students the second year; assumes that 25% will need a high cost service.
- Resources for 1.5 case/resource managers are included for the first year and 3.5 case/resource managers for the second.

Expand and phase-in day program resources for 350 people in need of services $ 2,400,000 ($2,000,000 GF-S)

- Provide resources to 350 children and/or adults in need of day program services; assumes 25% will need a high cost service.
- Resources for 1 case/resource manager are included for the first year and 1.5 case/resource managers for the second.

Provide individual employment for 200 people currently receiving specialized industries or community access services **$1,000,000 ($ 800,000 GF-S)**

■ Provides additional resources for people who want to become employed.

Individual and Family Support

Provide services for 3,969 people **$25,100,000 ($15,900,000 GF-S)**

■ Eliminates the waiting list for family support throughout the next biennium, adding 1,865 people to the program each year; all of whom would receive family support resources and a third or 1,244 would also receive personal care.

■ Includes 41.5 case/ resource managers and 9 support staff the first year and 58 case/resource managers and 13 support staff the second, to develop new services.

■ Increases the maximum allotment available for short-term intervention and community guide costs to $1,800/year.

■ Provides for respite and personal care rate increase (see provider staff turnover proposal).

2. Unmet Case/Resource Management Need

Add 116 field services staff to the regional offices $15,500,000 ($10,100,000 GF-S)

■ Includes 85 case/resource managers, 19 supervisory and clerical staff, 6 accountants, and 6 information system staff.

■ Reduces the gap, by a third, between the current number of case/resource management staff and the essential number of staff needed to comply with federal and state rules, ensure consumer health and safety, and monitor for quality assurance, during the 1999-2001 biennium.

■ Includes supervisory, clerical, and other staff required to support case/resource managers.

■ Since Strategy 2 of this plan proposes to initiate system restructuring planning, which may affect the future role of case/resource managers, a third or 28 of the case/ resource managers would be established as project staff.

3. Strengthening and Assuring Service Quality

Establish regional quality assurance teams **$ 2,100,000 ($ 1,400,000 GF-S)**

■ Provides 18 FTEs that report directly to the Regional Managers.

■ Provides the resources necessary to address fully the need to survey and evaluate services provided by the 12,000 individuals under contract with the Division.

Provide core and on-going training for provider staff **$ 6,200,000 ($ 4,100,000 GF-S)**

- Provides 38 hours of core training for all new residential, employment, day program, attendant care, and alternative living provider staff.
- Includes 12 hours of annual continuing education for all provider staff.

Increase residential evaluation rates **$ 85,000 ($ 56,000 GF-S)**

- Provides a 20% rate increase to make contracted evaluator rates competitive.

4. Community Provider Stabilization

The Division recommends the following provider rate increases in order to reduce provider staff turnover, reduce time for staff replacement, stabilize provider staff, and ensure staff continuity for the people receiving services:

Residential

Align the staff benchmark at 73% of the mid step of an Attendant Counselor II plus benefits and establish three geographic rate tiers that recognize cost-of-living variances **$22,400,000 ($11,900,000 GF-S)**

- Represents a first step in addressing the total need to stabilize residential direct care staff and community services.

Employment/Day Programs

Increase direct provider staff salaries & benefits **$ 3,300,000 ($ 2,800,000 GF-S)**

- Provides a 5% salary and benefits increase for approximately 1550 staff.
- Employment/day program staff salaries and the county service rate setting process will be further studied in order to determine how to adequately stabilize county/day programs.

Individual Providers

Increase the rate of $6.18/hour to $7.00/hour effective July 1, 1999 and $7.25/ hour effective July 1, 2000. **$17,400,000 ($9,100,000 GF-S)**

- Coordinate with the Aging and Adult Services Administration, specific to increasing the rates for personal care as they have the administrative responsibility for the Personal Care Program.

Adult Family Homes

Fund adult family homes at a level equivalent to what the Administration of Aging and Adult Services pays **$16,000,000 ($ 8,000,000 GF-S)**

■ Increase would fund the $600 per month rate variance for 1,120 people in Adult Family Homes.

5. Administrative Supports

Revise the method for collecting the unmet needs of people on the division's caseload and projected caseload growth needs **$ 400,000 ($ 250,000 GF-S)**

■ Funds the development of improved needs assessment tools required to prepare for Phases II and III.

Add five staff and infrastructure to meet critical information system and data needs **$ 2,100,000 ($ 1,400,000 GF-S)**

■ Provides staff and equipment to develop the information system improvements identified in Chapter 2.

Total 1999-2001 Biennium Funding Needs **$148,085,000 ($88,900,000 GF-S)**

Section 3: Comparison of Total Unmet Need and Strategy 1 Stabilization Recommendations

	Total Unmet Need	*Amount Recommended*	*Percent*
1. Unmet Service Need			
TOTAL	**$287 million ($170.9 GF-S)**	**$ 62.6 million ($39.8 GF-S)**	**21%**
Residential services	4,505 persons	425 persons	9%
Employment/Day prog./Birth-to-3	2,928 persons	1700 persons	58%
Individual/Family support	3,969 persons	3,969 persons	100%
2. Unmet Case Management Need			
TOTAL	**$ 43.4 million ($28.2 GF-S)**	**$ 15.5 million ($10.1 GF-S)**	**36%**
Case/resource managers	254 FTEs	85 FTEs	33%
Support staff	70 FTEs	31 FTEs	44%
3. Service Quality/Accountability			
TOTAL	**$ 8.4 million ($5.6 GF-S)**	**$ 8.4 million ($5.6 GF-S)**	**100%**
Staff	18 FTEs	18 FTEs	100%
4. Community Provider Stabilization			
TOTAL	**$105.3 million ($56.2 GF-S)**	**$59.1 million ($31.8 GF-S)**	**56%**
Residential	$44.0 million ($23.4 GF-S)	$22.4 million ($11.9 GF-S)	51%
Employment/day program	$ 3.3 million ($ 2.8 GF-S)	$ 3.3 million ($ 2.8 GF-S)	100%
Individual providers	$42.0 million ($22.0 GF-S)	$17.4 million ($ 9.1 GF-S)	41%
Adult family homes	$16.0 million ($ 8.0 GF-S)	$16.0 million ($ 8.0 GF-S)	100%
5. Administrative Supports			
TOTAL	**$ 2.5 million ($ 1.7 GF-S)**	**$ 2.5 million ($ 1.7 GF-S)**	**100%**
Staff	5 FTEs	5 FTEs	100%
Combined Total	**$446.6 million ($262.6 GF-S) Unmet Needs**	**$148.1 million ($89 GF-S) 1999-2001 Recommendation**	

(Note: Total unmet need for employment/day providers, adult family homes, and administrative supports are likely under-represented; further study will occur in preparation for Phase II.)

Chapter 4 Restructuring the System

SECTION 1: Introduction to Strategy 2 – Restructuring the System

Strategy 1, for the 1999-2001 biennium, responds to SSB-6751's charge to stabilize currently available services in residential habilitation centers and in the community. Strategy 2 takes the next step, "to develop recommendations on future directions and strategies for service delivery improvement, resulting in an agreement on the directions the department should follow in considering the respective roles of the residential habilitation centers and community support services, including a focus on the resources for people in need of services."

Strategy 2 is the "plan to plan" that will result in the statutory, and further budget recommendations "to secure for all persons with developmental disabilities the opportunity to choose where they live,"as required by SSB-6751. This strategy describes the process that the Division and the Stakeholder Workgroup will use to develop recommendations for restructuring the system. Strategy 2 represents a direction, as developed by the Stakeholder Workgroup, not a destination. Future system improvements are to conform to the principle of "choice." The primary theme of Strategy 2 is to enhance the ability of persons with developmental disabilities and their families to choose. There are also several additional areas that can be restructured to enhance system and service effectiveness, efficiency, quality, and flexibility. These will parallel and overlap the direction of enhancing choice.

SECTION 2: Strategy 2 Summary

The Division and the Stakeholder Workgroup are forming four workgroups to begin planning for system restructuring. The Stakeholder Workgroup developed goal statements for these workgroups in June 1998. The primary and largest workgroup (from 16-24 members) will focus on issues relating to choice. The three remaining workgroups, with about 12 members each, will focus on the three primary services needed by people: residential supports, employment and day program supports, and individual and family supports.

Each workgroup will be co-chaired by Division executive management and Stakeholder Workgroup members. The co-chairs will meet frequently with each other and the Division Director. Each workgroup will include people with developmental disabilities, Division staff, Stakeholder Workgroup members, and other interested constituents selected by the Division Director. The workgroups will be formed in December 1998 and begin formulating structured work plans in January 1999. The first several months will be devoted to the development of these work plans, which will then be submitted to the Division and reviewed with the Stakeholder Workgroup for final approval. After the plans are approved, the workgroups will pursue their work in

earnest, routinely bringing status reports and individual recommendations to the Stakeholder Workgroup for discussion and approval.

While the workgroups are developing their work plans, the Stakeholder Workgroup and the Division will resume the mediation process. The first six months of 1999 will be devoted to mediation of issues identified by the Stakeholders in 1998. An "agreement in principle" will be sought on each of these issues. These agreements will provide guidance to the workgroups as they develop their work plans and recommendations. At the conclusion of the mediation phase, the Stakeholder Workgroup will develop a meeting schedule conducive to supporting the activities of the four workgroups, preparing for reporting Phase I results and development of Phase II activities.

SECTION 3: Strategy 2 Workgroups

Choice Workgroup

Goal Statement: *The Division of Developmental Disabilities will restructure system administration and management to support an individual/family centered approach, with an emphasis on quality, access, responsiveness, efficient utilization of resources, and accountability.*

"Choice" means empowering people to choose what services they will use to satisfy their needs and who provides these services. Individuals and families also want the opportunity to participate in policy decision making with equal representation. Choice also shares a common bond with the national self-determination movement. This movement to increase the control people with developmental disabilities have over their lives, removing every unnecessary barrier, is well documented and growing. Many states are exploring choice and/or self-determination by creating pilot projects to test new ideas, usually supported by several years of planning.

As it builds its workplan, the Choice Workgroup will consider issues such as access to services, combining categorical funding, service quality assurance and stability, information access to what is available and possible, greater self-determination and control, achieving a well-trained and committed workforce, case/resource management, and responsible administration.

Another related aspect of choice is the "choice of residential living options" program authorized in SSB-6751. This provision established a limited funding process to allow people with the most serious and emergent needs to access their choice of either community or RHC placement. The Choice Workgroup is expected to propose the parameters that will characterize the first steps toward a restructured service system, and to suggest appropriate methods of piloting these new ideas in several general areas.

Residential Supports Workgroup

Goal Statement: *The Division … will design and maintain an effective system of residential supports and services that provides a full range of service options based on assessed needs, emphasizing choice and efficient resource utilization.*

Funding for residential support services consumes the vast majority of the Division's budget allocation, and waiting lists for these services in the community and for RHC services have existed for decades.

Community residential services have gradually developed to support people with the most severe disabling conditions. Financing these services has been largely accomplished through a Medicaid program, the Home and Community-Based Waiver, which allows federal matching funds to be applied to services for persons living in the community that otherwise would have financed services in an institutional setting. Under the Waiver, individualized settings have generally replaced large-group settings.

People with developmental disabilities who desire community residential services fall into several groups. People moving out of institutions made up the early waves of community residential participants. People with acute medical and/or behavioral support needs followed. A newer group receiving community residential services is the adult children of aging parents/relatives who are no longer able to be the primary caregivers. Young adults leaving high school and entering the world of work and independence are also primary consumers. People with acute behavioral challenges that are perceived to be, or have a history of being, dangerous to self and others, also depend on these services.

In addition to the residential services offered directly through the Division, people with developmental disabilities consume residential services provided through the Aging and Adult Services Administration (AASA), including boarding homes and adult family homes (AFH). AFHs have represented the greatest growth market in community residential services as funding for "developmentally disabled specific" residential programs stalled out in 1992. The mainstay of the AFH industry today is professionally managed dwellings that provide minimal supervision and paid supports.

The Residential Supports Workgroup will review all of the characteristics of current community and institutional residential program configurations, policies, and practices. It will also investigate other states' residential systems to learn about alternative practices that enhance personal responsibility and growth, increase quality assurance, and promote efficient use of resources.

Employment and Day Program Supports Workgroup

Goal Statement: *The Division … will design and maintain an effective system of employment and day program supports and services that support and foster access to full time employment for all working age adults in inclusive settings or provide other meaningful opportunities to be contributing participants in the vital activities of community life.*

Employment and day programs for adults are designed to increase participation in community life, enhancing the individual's sense of self worth and confidence by reducing his or her isolation from others. For most persons, this involves employment. Individual supported and group supported employment programs are designed to provide the maximum opportunity for earning significant wages and other economic and social benefits. For some persons, community employment goals are not pursued for medical, physical, and personal reasons. Specialized Industries and Community Access programs offer alternative activities and pre-vocational training.

Washington is one of the leading states in the nation in the percentage of people with developmental disabilities who are employed though individual supported employment. But access remains a problem; sizable waiting lists are common, and new access is obtained primarily by new high school graduates. In addition, supported employment wages have flattened out in recent years. Most supported employment participants are not advancing up the career ladder as they gain work experience.

In 1997, the Division commissioned the Washington Initiative for Supported Employment to develop an analytical paper describing these barriers in detail and offer recommendations to address problems and challenges. This workgroup will respond to each of the recommendations.

The workgroup will also help develop clear policies for using Specialized Industries, which many people believe offer relative stability and "fail safe" circumstances for people in transition between supported employment jobs. And it will develop recommendations for the state's Community Access programs, which are criticized for lacking specificity in design and outcome expectations.

(Also included in the "day program" category are education and therapeutic services for children ages birth-to-6. These services are not part of the focus of this workgroup. However, recommendations from the County Developmental Disabilities Boards and the State Interagency Coordinating Council (SICC) that oversee these services may be incorporated into the strategic plan.)

Individual and Family Supports Workgroup

Goal Statement: *The Division … will design and maintain a single, comprehensive system of individual and family supports.*

Individual and family supports are a broad array of state and federally funded services typically provided to assist people with developmental disabilities to stay in their own homes. Providers of these services may be contracted through the Division, or more directly through the individuals and families. Some of these services are administered outside of the Division.

There are several demanding challenges associated with these services. The Family Support program has two primary components. The original program required individuals and their families to be assessed and placed into three hierarchical need categories. Funding for services varied according to the need category. Respite services were the

primary service provided. This older component is gradually being phased out and replaced by the Options program alternative that grants more flexibility in the use of funds. Personal care services are also in this category. The individual or a family member would typically arrange for his or her own care. The provider network is not well established and the reimbursement rates are not considered competitive. The Medicaid personal care program is often combined with the Family Support program to provide needed services to individuals and their families.

The workgroup will develop recommendations to combine these divergent services into a unified, comprehensive system of in-home or individual and family supports characterized by a stable, capable workforce. This complex effort will involve participants from other administrations, provider representatives, and individual advocates. The workgroup may also focus on services and supports that are provided in the person's home, in contrast to those provided in a provider's residence or facility, such as Alternative Living.

Chapter 5 Preparing for Phases II and III

Phase I is intended to stabilize current services and begin the planning for restructuring the service delivery system. Several pilot projects are anticipated to begin during the 1999-2001 biennium to test proposed changes. The Division also plans to improve the tools needed to perform needs assessments and trend analyses.

The Phase II portion of the long-range strategic plan will be prepared during 2000 and delivered to the Legislature on December 1, 2000. The Division will endeavor to complete any budget and statutory recommendations, including an update on the unmet needs analysis, in time to be part of the 2001-2003 budget preparation cycle.

Preparation for Phase III will follow the same outline and be delivered to the Legislature on December 1, 2002. The Phase III report will primarily focus on system restructuring objectives and activities in all areas of service design, service delivery, and system administration. The Phase III report will also make specific recommendations regarding the future of RHC services, as SSB-6751 is scheduled to expire on June 30, 2003. Throughout Phases II and III, the Division will make available Stakeholder Workgroup status reports, as well as working papers and recommendations from the workgroups, as appropriate.

Appendix A

DDD Strategies for the Future – 1999-2005 Long-Range Strategic Plan
Information Guide November 1998

DIVISION OF DEVELOPMENTAL DISABILITIES

Department of Social and Health Services

This Information Guide is intended to provide a brief overview of the Division of Developmental Disabilities, in terms of authorizing statutory references, Mission, Vision, and Values, and current services provided. Reference is also made to SSB-6751, passed by the Legislature in 1998, as it relates to the Division's strategic planning activities and cooperative relationship to the Strategies for the Future Stakeholder Workgroup. For more detailed information, please contact Division staff at 360-902-8484.

I. STATUTORY AUTHORITY

A. Washington State Constitution- Article XIII, Section 1 - Requires the state to foster and support "educational, reformatory, and penal institutions" that are for the benefit of youth who are blind and deaf or otherwise disabled; for persons who are mentally ill or developmentally disabled; and other institutions as the public good may require…"

B. Revised Code of Washington - 71A This chapter organizes and clarifies laws regarding the provision of service to persons with developmental disabilities. The key sections of the chapter are:

RCW 71A.10.020	Definitions of developmental disabilities
RCW 71A.10.015	Service obligations
RCW 71A.12.010	Authority to develop and coordinate state services
RCW 71A.12.030	Statutory duties and responsibilities
RCW 71A.12.020	Service Requirements
RCW 71A.10.020(4)	Habilitative services defined
RCW 71A.12.040	Authorized services listed
RCW 71A.14	Local service options outlined
RCW 71A. 14.080	Local authority defined
RCW 71A.16.010	Service eligibility
RCW 71A.18	Special conditions for services
RCW 71A.20	Residential Habilitation Center operations
RCW 71A.22.010	Authorizes training centers and homes

Revised Code of Washington - 74.09.120 Authorizes the state to purchase services and care in Institutions for the Mentally Retarded.

Revised Code of Washington - 74.09.520 Authorizes the Department of Social and Health Services to provide Medicaid Personal Care.

Revised Code of Washington - 70.195 The Department of Social and Health Services is designated as the lead agency to implement a comprehensive and coordinated state-wide system of early intervention services for eligible infants and toddlers with disabilities.

II. VISION, MISSION, CORE VALUES

A. VISION

People with developmental disabilities and their families are valued citizens of the state of Washington. Washington State public policies will promote individual worth, self-respect, and dignity such that each individual is valued as a contributing member of their community.

B. MISSION STATEMENT

The Division of Developmental Disabilities will endeavor to make a positive difference in the lives of people eligible for services, through offering quality supports and services that are: individual/family driven; stable and flexible; satisfying to the person and their family; and able to meet individual needs. Supports and services shall be offered in ways that ensure people have the necessary information to make decisions about their options and provide optimum opportunities for success.

C. CORE VALUES

1. INDIVIDUAL WORTH AND DEVELOPMENT

People will be served with dignity and with respect for individual differences and be supported to experience the: benefits of relationships with friends and families; personal power and choice; personal value and positive recognition by self and others; integration; competence to manage daily activities and pursue personal goals; and health and safety.

2. CONTINUITY AND COORDINATION OF SERVICES

Services will be provided in a flexible system, which enables people to remain in their own homes and communities whenever possible.

3. COMMUNITY PARTICIPATION AND PARTNERSHIP

Services and supports will promote the participation and partnership of consumers, parents, service providers, advocates, local governments, citizens and businesses.

D. RESPECT FOR EMPLOYEES

Employees will be treated as the Division's most valuable resource.

E. SERVICES QUALITY AND PERFORMANCE ACCOUNTABILITY

The division is accountable to the public for effective and prudent use of resources. The Division will conduct regular review, evaluation, and modifications of programs and services.

F. NON-DISCRIMINATION

The Division will not discriminate on the basis of sex, race, color, religion, national origin, age, disability, or sexual orientation/perceived sexual orientation in admission and access to services, treatment, or employment.

III. SERVICE DESCRIPTIONS

The Division provides a broad range of services and supports to over 27,000 eligible clients. These services may be direct or indirect and may occur either in an individual's home or in another setting. The services may be provided by state employees and/or by contracted providers. The Division operates six regional offices located throughout the state.

A. Case and Resource Management - The initial service provided by the Division is eligibility determination. A case manager assesses the individual and/or families' needs and authorizes/contracts for needed available services. Additional responsibilities of case managers include: development of individual service plans; providing information about available services; ; arranging for service delivery; authorizing payments for publicly funded services; referring persons to other sources of support; and crisis intervention.

B. Community Residential Services - These services are provided to persons who require assistance with daily living and do not live at home. The Division contracts for these services with organizations or

individuals that provide varying levels of assistance. Services include both facility based and non-facility based programs.

1. Facility Based Programs - In these residential programs, room and board are included in the rate paid by the Division. They include: Group Homes, which range in size from 3 to 35 residents and provide on-site supervision during all hours when clients are in the facility; and Intermediate Care Facilities for the Mentally Retarded (ICF/MR's), which are programs housing from 6 to 40 individuals that offer more intensive nursing, therapy services, and work-related assistance. These facilities must meet federal standards and receive matching funds through Title XIX, Medicaid.

2. Non-Facility Based Programs - These programs provide support and assistance to persons living in their own homes in the community that they rent. The Division provides staffing support, while clients pay for rent, food, and other personal expenses. Supportive Living programs include: Alternative Living, Tenant Support (provides support on a flexible schedule), and Intensive Tenant Support, (provides 24-hour supports). These programs are provided through private agencies that contract directly with the Division. Staff provide direct training and assistance on a flexible schedule according to the individual's needs. State Operated Living Alternatives (SOLA) provide similar services to those described above but are staffed by state employees.

C. Other DSHS Facilities - In addition to the residential programs directly operated or contracted by the Division, many clients receive services in settings funded through or operated by other DSHS programs. These include: Adult Family Homes (house up to six person who cannot live alone but do not require skilled nursing care); Nursing Facilities (provide an extensive array of services for persons requiring daily nursing care, assistance with medication, eating, dressing, or other personal needs); Adult Residential Care Facilities (provide 24-hour supervision and assistance with activities of daily living within a licensed boarding facility); and Foster Care, (provides out-of-home contracted residential care for children who cannot live with their parents).

D. Residential Habilitation Centers - Residential Habilitation Centers (RHCs) are state-operated residential facilities that provide a comprehensive array of clinical and support services within a 24-hour setting. RHCs are federally certified facilities and receive matching funds through Title XIX, Medicaid. Services are provided based upon Individual Habilitation Plans and typically include: habilitation; training; adult education; an array of specialized therapies, nursing, medical, and dental care; and recreation services. There are five RHCs located state-wide: Fircrest School in Seattle serves 343 individuals and is certified partly as a Nursing Facility and partly as an Intermediate Care Facility for the Mentally Retarded (ICF/MR); Lakeland Village in Medical Lake serves 289 persons and is similarly certified partly as a Nursing Facility and partly as an ICF/MR; Yakima Valley School in Selah serves 128 individuals and is certified entirely as a Nursing Facility; Rainier School in Buckley serves 447 persons and is certified entirely as an ICF/MR; and Frances Haddon Morgan Center in Bremerton serves 56 persons with autism and is also certified entirely as an ICF/MR.

E. Employment and Day Programs - Approximately one third of the persons enrolled by the Division are involved in some type of day program. These programs are funded by the Division through contracts with counties who select and contract with service providers. Day programming provides either employment related support and vocational opportunities or other non-employment related activities to adults to help them integrate into the community. For children, day programming is primarily education and therapeutic service oriented. These services include:

1. Child Development Services - Counties contract with agencies to provide therapy, education, family counseling, and training and is provided to children until age three (when they become eligible for services through public schools).

2. Employment Services - The Division funds counties to contract for three types of employment programs: Individual Employment (assists individuals with finding and keeping jobs in private businesses. These programs match participant interests and skills to available community jobs, provide extensive on-the-job training, offer training to supervisors and co-workers, and provide ongoing support); Group

Supported Employment (enable individuals to work in community settings in supervised groups of no more than eight persons); and Specialized Industries (provide pre-vocational training in a sheltered setting).

3. Community Access Services - Counties contract with agencies to provide services that emphasize the development of social, communication, and leisure skills for individuals whose age or disability limits their participation in employment. Persons gain access to community activities through special assistance, advocacy, and education.

F. Infant and Toddler Early Intervention Program (transferred to the Division in the 1995-97 budget) - This is a federally funded "enhancement" program for infants and toddlers with developmental disabilities and delays, and their families. Early intervention services are contracted for in each of the state's geographical areas, providing funding to assist families to access and coordinate needed resources and to enhance/improve existing resources.

G. Family Support Services - Provides families with the supports necessary to keep individuals at home or with relatives. These services include: Respite Care, therapies, and a variety of other services providing in or out-of-home care in order to provide short-term relief to the family. The Family Support Opportunity program builds on community and informal resources, offers the assistance of a community guide, and the availability of other resources.

H. Professional Support Services - The Division funds a variety of professional services that enhance the functional and adaptive skills of individuals. These services include: Counseling and Therapeutic Services (psychological services, professional evaluations required by the courts, and other therapeutic services); and Supplemental Community Support (provides professional services to individuals living apart from their families).

I. Medicaid Personal Care - This is a federally matched entitlement program that provides assistance with the activities of daily living to individuals living in their own homes, Adult Family Homes, or Congregate Care Facilities. The Division has historically determined eligibility and funding for children, while the Adult Personal Care program was transferred to the Division in the 1995-97 budget.

J. Voluntary Placement and Foster Care Program - As of fall 1998, children with developmental disabilities who are under 18 years of age may be eligible for foster care placement and support services. The voluntary placement of a child must be by mutual agreement between the family and the Division of Developmental Disabilities. The foster placement is viewed as a positive support to the family and child or youth that may be placed in such an arrangement for a period of time. Each of the six DDD regions has a voluntary program supervisor and social worker to manage requests for these services that are delivered under very specific circumstances.

IV. DDD STRATEGIES FOR THE FUTURE STAKEHOLDER WORKGROUP

In February 1997, the Secretary of the Department of Social and Health Services and the Chair of the Senate Health and Long-Term Care Committee challenged the Division's stakeholders to construct a unified approach to the Division's funding and major policy issues. The Secretary formed the DDD Strategies for the Future Stakeholder Workgroup in June of 1997. Nineteen stakeholders, affiliated with all aspects of the developmental disabilities community, came together to build consensus and a plan to adequately fund the Division's services. Using a mediation strategy, the Stakeholder Workgroup built an Agreement in Principle that laid the foundation for addressing both funding for unmet needs and the historical conflict between institutional and community-based service policies and preferences. The Stakeholders recommended that if people met an RHC "funded level of need" criteria, they could apply for admission if an alternative community placement could also be offered. In order for this "choice" mechanism to function, community services needed to be stabilized, expanded, and invested with the same permanency that had been afforded institutional services. After these investments were made, the market (as determined by individual/family choice) would determine the future mix or availability of various services. The Agreement in Principle also recommended that a restructuring of the entire service delivery system be investigated to improve quality, access, and the individual's and families' sense of control over their own services.

The Agreement in Principle was widely distributed in January 1998. The Senate Health and Long-Term Care Committee Chairman decided to formulate legislation that embodied the Agreement in Principle. SSB-6751 was eventually passed by the Legislature and signed by the Governor at the end of March 1998. This legislation furthered the "choice" features of the Agreement in Principle, creating a funding mechanism and process that allowed certain individuals to access current residential habilitation center (RHC) vacancies or alternative community programs. In addition, the legislation required the Division to conduct the unmet need analysis and strategic plan articulated in the Agreement in Principle, and directed the Division to continue to work with the Stakeholder Workgroup to realize these objectives over the three biennia planning period. Phase I will cover July 1, 1999 through June 30, 2001. Phase II will address the next two year period and Phase III will address the final two years of the planning period.

Appendix B

Analysis of Unmet Service Needs - Research and Data Analysis Summary

Purpose

In January 1998, the Division of Developmental Disabilities (DDD) contracted with Research and Data Analysis (RDA) to perform an analysis of their unmet needs list. The purpose of the unmet needs list is to provide information about needed supports for persons with developmental disabilities to case managers, the Division of Developmental Disabilities, counties and the legislature.

The goal of the analysis was to determine the magnitude of the unmet need problem, explore types of needs among the caseload, and estimate the associated cost of meeting the needs identified. For a detailed description of the unmet needs list analysis, see RDA technical report #5-29A.

Methods

Since its inception in 1993, the unmet needs list has been criticized on numerous fronts. Major concerns include the frequency of updating and whether case managers can accurately assess persons' needs are. Research staff performed some preliminary analyses verifying that the unmet needs list is reasonably accurate, at least on an aggregate level. By comparing the unmet needs forms completed by case managers, to reports of needs obtained directly from caseload members and their families/significant others, a strong degree of correspondence was found between the general types of services individuals and families say they want and what their case managers request for them, particularly in regard to residential and day program services.

Research staff also explored the needs of persons with specific characteristics as measured by the DD Complex Characteristics survey1, Comprehensive Assessment scores2, and the community protection list3. In general, case managers requested the types of services one would expect persons with a specific characteristic to need.

Research staff conducted two surveys to help expand the information about unmet need:

1. Some people have had little contact with their case manager and have not been receiving services paid through the Division; thus, a case manager may not be familiar with these persons' needs. Some people may also be receiving services that cannot be tracked through payment system records because they are being paid for through other sources or the services do not generate an individually identifiable payment record. Case managers of a subset of individuals with a "no needs" record and no service records were contacted. If the case manager felt that he/she sufficiently knew the individual and his/her needs, staff collected information on needs and services received. If the case manager did not have significant knowledge of the person, the interviewers attempted to gather information during a telephone interview from the individual's significant other as indicated in DDD records.

2. The second survey obtained further information about the category of "other need" on the unmet needs form. While there is space on the unmet needs form to write a text description of the need, this text description is not kept electronically at headquarters. RDA staff selected a sample of persons with an "other need" for follow up. Case managers of these persons were contacted and asked to provide clarification of the "other need." Where this "other need" could be met by one of the options on the unmet needs form, a new item was added to the person's unmet needs profile. The results from these two surveys were used to estimate additional needs.

Next staff performed some cleaning of the unmet needs list. Because the list is not consistently updated, staff removed requests that were no longer appropriate for a person's age and requests for services that had already been received. They also removed requests for services that a person was not yet old enough to receive, as DDD did not intend to change their practices for offering services during the next biennium.

The Time Frame for the Study

Case managers were directed to update the unmet needs list in December 1997. FY97 was chosen as the base year for the analysis of unmet needs as completed records are available (many service payment systems have a lag time of up to 6 months). The analysis is focused on the set of persons who were on the caseload at some time during FY 1997, the services they received during that year, and their remaining unmet service needs as reported on the unmet needs list as of the time research staff obtained the list in January 1998.

Results

How many people are getting services relative to number of persons with needs?

Some persons seek eligibility for DDD, although they have no need for services at the present time ("No Request"). People seek eligibility to reduce the speed at which services could be received in an emergency.

Other people seek eligibility from the Division because they currently have a need for services. The Division does not have enough resources available to meet the needs of all these persons, so needs remain totally unmet for some people and partially unmet for others. Persons for whom the Division is providing services of some type, but not the type desired, or who have other needs yet to be met, are referred to as the "underserved." Persons for whom the Division is not providing any services, but who have an identified need, are referred to as the "unserved."

In order to explore how well the Division is able to meet the needs of persons on their caseload, unmet needs and service information were combined to create the following 2 x 2 frequency distribution (Table1). These results include survey adjustments.

Table 1: Unmet Need – by Services Received during FY97
Identified as having an unmet need, Dec.1997, Jan. 1998
Receiving DDD, AASA, DCFS, DVR Services in FY97
Caseload + 26,125 as of June 1997

Receiving Services? No Unmet Need	Receiving Services? No Unmet Need	Receiving Services? No Unmet Need	Receiving Services? No Unmet Need
16,254	4,016	2,977	2,878
62%	15%	11%	11%
Served	**Underserved**	**Under Review**	**Unserved**

This table shows that the Division, and other agencies, are fully meeting the needs of 62 percent of their caseload, partially meeting the needs of 16 percent of their caseload, and not meeting any needs for 11 percent of their caseload.

The 11 percent of the caseload for whom the Division is providing no services and who have no needs are presumed to be persons who are capable of meeting all of their own needs, or whose needs are being met through other DSHS divisions not included in the assessment, or through other personal or community resources.

What types of services do people need and what are the associated costs?

Specific services on the unmet needs form were combined into three types: Residential, Day Program, and Family Support. Residential contains all residential service options on the unmet needs form, including non-DDD controlled settings such as Children's Foster Homes, Adult Family Homes, and Congregate Care Facilities. Day Programs contains all county funded employment or day programs, including Child Development Services. Family Support is a broad category that contains the family support program, as well as needs for attendant care, personal care, nursing services, or therapies.

These three types of needs, with high versus low levels of anticipated cost for those services, create 10

possible categories of need. High cost is defined by a need for counseling/behavior management, mental health services, or nursing services in combination with another need. Our assumption is that these persons, in general, are more likely to require higher supervision or care and thus the cost for providing services is likely to be greater than for those who do not have these requirements. Estimated costs to provide services are based on typical costs for similar services during FY 1997, plus a 3 percent rate increase that occurred as of July 1, 1997. For the Underserved, research staff took the additional step of determining savings due to services no longer required once needs are met.

Table 2 presents the number of persons and associated cost to meet all needs, assuming that the waiting list as of FY 1997 is eliminated during the next biennium.

Table 2: Biennial Cost to Serve FY97 Unmet Need

Needs Categories	Persons	Biennial Cost
1. Residential	1,522	$ 55,633,806
2. Residential - High Cost	173	$ 29,382,781
3. Residential/Day Program	728	$ 22,813,665
4. Residential/Day Program - High Cost	112	$ 21,813,687
5. Day Program Only	1,240	$ 11,556,406
6. Day Program Only - High Cost	116	$ 2,217,215
7. Day Program/Family Support	172	$ 2,409,600
8. Day Program/Family Support - High Cost	50	$ 2,389,905
9. Family Support Only	1,848	$ 6,005,475
10. Family Support - High Cost	1,066	$ 20,060,270
TOTALS	**7,021**	**$174,282,810**

As of the end of FY 1997, people on the Division's caseload were in need of:

- 2,535 new residential services or changes in placements,
- 2,418 new day program services or changes in day program placements, including 200 people who want to be employed currently in Specialized Industries or Community Access
- 3,136 family support, attendant care, or therapy placements

The projected cost to meet all the needs of these 7,021 persons is in excess of $ 174 million.4

As a person's service needs are met, their unmet needs record includes only remaining needs and no longer provides a complete picture of that individual's support requirements. The number of persons in a category in Table 2 represents only the type of needs that remain to be met. For example, a person who requires both a typical residential placement and a day program will appear in category 3 before receiving services, but once a day program is received, the same person will appear in category 1. The number of persons per category is therefore not comparable to the analysis presented below, although overall need and cost can be compared.

How many persons are expected to be on the unmet needs list as of the end of the next biennium (FY01) and what are the associated costs?

Because the unmet needs list is non-historical and only covers needs remaining to be met, research staff combined a person's service information with their unmet needs record to create a profile of the total support requirements of each person on the FY 1997 caseload. This information was summarized and

categorized into 10 categories, similar to those used for the FY 1997 unmet needs analysis, but the categories now reflect support requirements rather than just needs that remain to be met. Table 3 presents the number of persons on the FY 1997 caseload by the type of supports they require. These numbers include survey adjustments.

Table 3: Current (FY97) Support Requirements

Support Categories	Frequency	Percent
1. Residential	2,916	11%
2. Residential - High Cost	432	2%
3. Residential/Day Program	4,311	17%
4. Residential/Day Program - High Cost	1,694	6%
5. Day Program Only	2,141	8%
6. Day Program Only - High Cost	125	0%
7. Day Program/Family Support	261	1%
8. Day Program/Family Support - High Cost	273	1%
9. Family Support Only	3,261	12%
10. Family Support - High Cost	3,923	15%
TOTAL Caseload	**26,125**	

These frequencies represent a minimal number of persons who require support from the Division. They include only those identified as having a need or who are currently receiving services. There may be others whom the Division should serve that have not expressed a desire for services (e.g., persons with community protection issues or living in an inadequate situation).

The above numbers include early childhood services and transition services to the extent that persons have actually sought out and received those services. Ideally, all persons of these ages should be offered these services, but historically only half of transition age students approach the Division for services.

Staff next performed an age-adjusted linear caseload projection based on the average growth in number of persons on the caseload since FY 1993. These projections provide an estimated caseload size through FY 2001.

Table 4: Age Adjusted Caseload Projections

Fiscal Year Counts include total persons expected to be on the caseload at any time in the fiscal year.

Age Group	FY98	FY99	FY00	FY01
0-2	2,075	2,132	2,191	2,251
3-17	10,448	11,805	13,341	15,082
18-21	1,998	2,160	2,335	2,525
22-39	7,761	7,982	8,210	8,445
40-49	3,093	3,315	3,553	3,808
50-59	1,683	1,864	2,064	2,286
60+	1,116	1,180	1,248	1,319
TOTALS	**28,174**	**30,438**	**32,942**	**35,716**

Since no historical information on support requirements exists, staff made the assumption that support requirements for the FY 2001 caseload will be reasonably similar to those of the FY 1997 caseload. While staff are aware that the nature of the caseload is changing, they do not anticipate dramatic changes over the short time frame of four years. Staff calculated the percentage of persons within an age group for each of the 10 support categories and applied the same percentages to the projected FY 2001caseload. Projected support requirements by fiscal year are displayed in Table 5.

Table 5: Projected support Requirements

Support Categories	FY98	FY99	FY00	FY01
1. Residential	3,118	3,339	3,579	3,842
2. Residential - High Cost	469	509	553	602
3. Residential/Day Program	4,531	4,767	5,018	5,286
4. Residential/Day Program - High Cost	1,792	1,897	2,010	2,132
5. Day Program Only	2,239	2,343	2,453	2,571
6. Day Program Only - High Cost	131	138	144	152
7. Day Program/Family Support	274	287	301	316
8. Day Program/Family Support - High Cost	284	296	308	321
9. Family Support Only	3,653	4,074	4,549	5,084
10. Family Support - High Cost	4,318	4,762	5,259	5,818
TOTALS	**20,809**	**22,412**	**24,174**	**26,124**

From here, staff subtracted the number of services currently available in the DDD system and service development anticipated throughout the 1997-1999 Biennium based on administrative plans and supplemental funding for Fiscal Year 1998.

The legislature provided funding for the Division to add 217 residential and 977 day program services during the 1997-1999 Biennium, and reduced the family support waiting list by 3,537 persons. Staff subtracted the number of additional services anticipated to be available through turnover. The result is the number of additional services required to meet everyone's needs by the end of the 1999-2001 Biennium.

RDA staff calculated cost of providing these services using techniques similar to the FY 1997 unmet needs analysis. Table 6 presents the number of persons expected to be on the unmet needs list as of FY 2001 and the cost associated with meeting these needs. These costs are in addition to extensive planned service development during the 97-99 Biennium and FY 1998 supplemental funding.

Table 6: Biennial Cost to Serve FY 2001 Unmet Need

Needs Categories	Persons	Biennial Cost
1. Residential	1,595	$ 64,229,389
2. Residential - High Cost	130	$ 18,454,884
3. Residential/Day Program	2,391	$ 78,824,580
4. Residential/Day Program - High Cost	389	$ 60,678,682
5. Day Program Only	405	$ 3,050,600
6. Day Program Only - High Cost	90	$ 1,308,270
7. Day Program/Family Support	50	$ 226,648
8. Day Program/Family Support - High Cost	196	$ 8,565,147
9. Family Support Only	1,454	$ 3,752,804
10. Family Support - High Cost	2,272	$ 47,860,512
TOTALS	**8,972**	**$286,951,516**

If the Division receives no additional funding to expand services during the next biennium, wating lists5 are anticipated to be:

- 4,504 residential placements, including 1192 students who will be transitioning from school
- 2,927 day program placements
- 3,964 family support placements

The projected cost to meet all of the anticipated unmet needs for the FY 2001 caseload is nearly $287 million. Thus, failure to obtain additional funding for the 99-01 Biennium would mean that the gap in number of available services as of the close of the Biennium would be even greater than it was as of the 95-97 Biennium. Substantial service development during the current Biennium and FY 1998 supplemental funding are insufficient to counteract the anticipated caseload growth.

1) The Prevalence of Complex Characteristics survey was conducted as part of a larger case/resource manager workload study. The survey identifies persons who have characteristics that might exacerbate time spent in case management services or complicate service delivery. For further information on this survey, see RDA technical report #5.30B.

2) The Comprehensive Assessment is used to determine the number of hours a person is authorized to receive though the Medicaid Personal Care program. It assesses the person's level of functional ability and needed supports.

3) DDD maintains a list of persons who are known to be at high risk of endangering others. For purposes of verification, the study only reviewed persons with the highest risk level.

4) Costs include direct costs for providing services, resource development and start-up costs to place a person into a services, county administrative costs, and costs associated with staff training.

5) The sum of the appropriate categories in Table 6 will exceed waiting list totals as they include "underserved" persons (those with partially met needs).

Appendix C

Defining Essential Work in Case/Resource Management - Research and Data Analysis Summary

Using a previously successful process completed by DSHS Division of Children and Family Services, DDD established a research project that would measure the workload of its case/resource managers and construct a set of essential standards for case/resource management with which to compare the work that was actually being done with the essential work that should be done. An in-depth examination of the study results will be published in Research and Data Analysis technical paper #5.30A.

Purposes of the Study

- Provide a scientific measurement of how long it takes case/resource managers to provide community case management and community resource development and management services to clients of DDD.
- Develop essential workload standards for the provision of services in DDD and compare the current workload with such standards.
- Provide the tools for DDD to develop projections of statewide and regional staffing needs based on: essential workload as described in the standards, caseload growth, and the effects of policy changes and program growth.

Methods

1. *Scientific time measurement of workload*

- Case/resource managers participated in a four-week total time (100%) measurement split between two ten-day work segments. (November 3-17, 1997 and April 17-30, 1998).
- Case/resource managers also participated in a one-month tracking of a statewide random sample of DDD clients, with an additional over-sampling of clients with complex characteristics and situations (February 1998).

2. *Development of essential workload standards*

Under the guidance of two national consultants, a group of case/resource managers, supervisors and regional administrators, who are experienced in the field of developmental disabilities, developed a set of essential workload standards. The consultants were John D. Fluke, Ph.D., Director, Program Analysis and Research, Children's Division, The American Humane Association and Homer Kern, Ph. D., Professor, Department of Human Services, University of Texas (retired). As the group of experts and the consultants methodically developed each essential standard for the typical caseload, they used the actual times observed and the activities accomplished during the February 1998 data collection as a basis for their decisions. They looked at the time actually spent and determined how much longer the activities should have taken according to mandates and requirements. Each of the decisions was made by consensus.

- They listed the steps and activities that are needed to complete a process.
- They examined how long each activity actually took and looked at which activities should be done differently, were not done long enough, or not done at all.
- They determined for how many people and how often each activity should be done.
- They met again two months later to review the times established for the phases in each program and made any needed adjustments.

3. *Prevalence survey regarding complex characteristics and situations of current individuals on the DDD caseload*

Case/resource managers responded to a survey of more than 10% of their client caseloads. They indicated

which of the sampled clients had certain complex characteristics in the random sample used in February 1998, described in item 1 above.

4. *Development of a calculation system for projecting staffing needs depending on trends in:*

- overall caseload growth
- projected increases in services
- estimated expansion of DDD funded services to address unmet need

Key Findings

How many people do case/resource managers actually contact on a yearly basis?

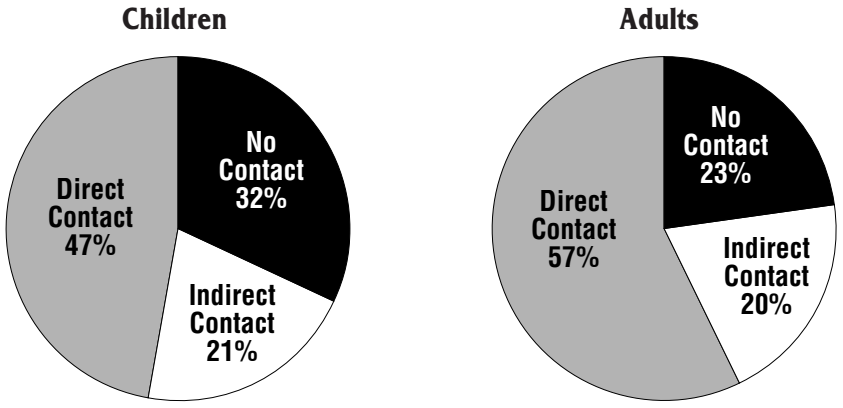
As the number of people assigned to each case/resource manager has grown, DDD has been concerned that many people who are officially on the DDD caseload have not been contacted, their addresses not checked, and their support needs not assessed. Three categories were explored to see which one applied to each client:

1) direct contact with client or family by phone or in person,

2) indirect contact through collateral contacts or paperwork,

3) no contact with the case/resource manager.

Figure 1: Contact with Case/Resource Manager in 1997



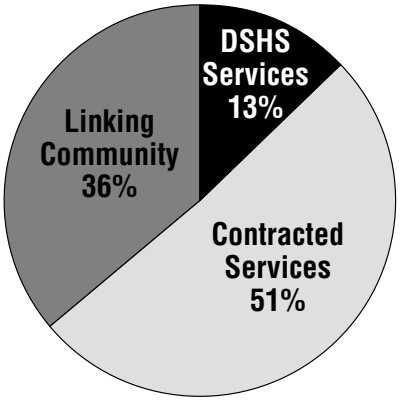
- 32% of children and 23% of adults had no contact with a case/resource manager in 1997.
- 21% of children and 20% of adults had only indirect contact.
- 47% of children and 57% of adults had direct contact.

What kinds of supports case/resource managers offer to persons contacted?

The February 1998 tracking of a statewide sample of DDD clients showed that:

- only half the time was spent of DDD funded services;
- the remaining time was spent mostly on linking people to community resources, providing supports to persons living in their own homes or parent/relative home, and linking to other available DSHS services not covered in DDD contracted services.

Figure 2: Percent of time spent linking services and supports in 1997

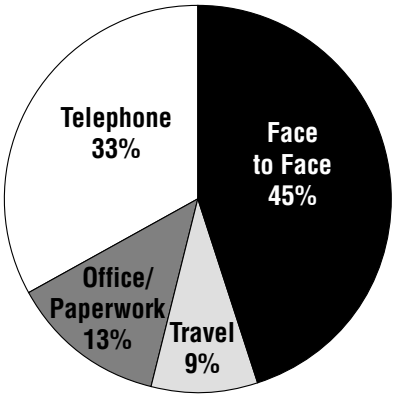


How much time did staff spend on paperwork and personal contacts?

The November 1997 total time measurement showed how staff spent case management time:

- most time, 45%, was spent on face-to-face contacts with clients, families, providers, and others;
- 33% of the time was spent on the phone, mainly with providers and families; and
- only 13% of the time was spent on paperwork and other in-office activities.

Figure 3: Percent of time spent on paperwork and personal contacts in 1997



How much time was spent on different types of clients or situations:

A large number of clients had special needs in addition to developmental disabilities. Some were persons with community protection issues, mental illness, drug/alcohol problems, behavior problems, language/ cultural differences. Others were in special situations—legal problems, living in psychiatric hospitals, living with families with coping difficulties, involved in protective service issues.

About half of all DDD clients had one or more of these characteristics or situations, above and beyond needing supports due to their developmental disability. In the February 1998 tracking study, we were able to sample clients with these special characteristics or situations and found that up to four times more time was spent with these persons than with the average person on the caseload.

Figure 4: Percentage of Time Spent Compared to the Time Spent to Serve an Average Person with Developmental Disabilities

Special Characteristics	Percent
Contact with Legal Services	438%
Living in Psychiatric Hospitals	405%
With Community Protection Issues	395%
With Alcohol and Drug Use Problems	373%
With Mental Illnes	325%
Family Has Difficulty Coping	190%
In Need of Protective Services	188%
With Behavior Problems	175%
With Physical Problems	153%
With Language/Cultural Differences	145%
Client Is a Parent	133%
Medically Intensive*	73%
Average Person with Developmental Disability	100%

*Medically intensive-these people typically have 24 hour nursing services in their home which would decrease the need for case management involvement.

Extra FTEs Needed: *How many extra case/resource managers (FTEs) would be needed to fulfill essential workload tasks currently not being done or done inadequately with each client on the DDD caseload?*

Answering this question involved calculating the following:

1) the number of FTEs necessary to meet essential minimum standards with the people who have not been contacted, so that everybody has been contacted;

2) the number of FTEs necessary to fulfill essential case management requirements tied not only to different support programs, but, more specifically, to different phases of case management work:

- connecting to needed supports;
- monitoring the effectiveness of the supports; and
- reviewing periodically their adequacy to changing needs.

3) the number of resource management FTEs necessary to fulfill mandates to develop, maintain and periodically evaluate resources (agencies, individual contractors, community capabilities) to provide needed supports;

4) the number of FTEs necessary to fulfill essential tasks related to intake-eligibility determination and periodic eligibility reviews.

In 1997 the following extra FTEs would have been necessary to fill the gap

between actual and essential workload standards:

Figure 5: 1997 FTE Gap

Work Activity	Actual FTEs	Extra FTEs
Unseen	0	22
Case Management		
Connection	40	24
Monitoring	52	90
Review	14	27
Resource Management	44	21
Intake/Review	13	12
Total	**161**	**198**

Additional FTEs would have been needed for the following purposes:

- 22 extra FTEs to contact and assess the support needs of the people who have not been contacted, and, when needed, to connect them with support services;
- 24 FTEs for the connection phase of case management, an increase of 60%;
- 90 FTEs, almost tripling the actual FTEs, for the monitoring phase of case management, indicating that this is one of the main areas that case/resource managers have cut corners when pressed with large caseloads;
- 27 FTEs for the review phase of Case Management, almost tripling the FTEs for review, indicating that many parts of the review phase are being done much below standards;
- 21 FTEs for Resource Management, including recruitment of new individual providers which accounts for a third of this increase;
- 11 FTEs for Intake/Review activities, mainly for eligibility reviews not currently being done in a timely manner.

In total, the extra FTEs needed to fulfill all essential aspects of case management amount to 198. Adding these additional case managers would have decreased existing 1997 caseloads from 141 to 1 to approximately 65 to 1.

What increases in FTEs and funding would be needed to fulfill all essential mandates in the next biennium, taking into account not only the growth in the DDD caseload, but also the case management work necessary to increase services to completely fill all unmet service needs?

1) In addition to the 198 case/resource managers needed to complete essential workload in 1997, supervisory and administrative support staff must also be included.

2) The anticipated 7% growth in the total DDD caseload will affect the workload of case/resource managers, even if DDD funding for services does not increase. For example, work related to community linking and connection to other DSHS services is a function of number of people on the caseload, not the amount of DDD contracted services.

Figure 6: FTEs Needed with No Increase in Services

Case Management Need	1997 Gap (for 24,000 clients)		1997-2001 Increase (for 33,550 clients)		Total Extra Needed by 2001	
	Extra FTEs Needed	Cost	Extra FTEs Needed	Cost	Extra FTEs Needed	Cost
Unseen Clients	22.4	$1,531,460	9.0	$615,141	31.4	$2,146,601
Case Management	142.3	$9,727,350	37.6	$2,569,922	179.9	$12,297,272
Resource Management	21.5	$1,468,300	0.0	$0	21.5	$1,468,300
Intake and Eligibility Reviews	11.7	$801,996	9.0	$615,141	20.7	$1,417,137
Case/Resource Manage. Total	**197.9**	**$13,529,106**	**56.0**	**$3,800,204**	**253.9**	**$17,329,310**
Supervisors+Admin. Support**	56.5	$3,561,045	13.0	$784,976	69.5	$4,346,020
Total FTEs and Annual Costs	**254.5**	**$17,090,150**	**69.0**	**$4,585,180**	**325.5**	**$21,675,330**

*This number includes not only caseload growth (38FTEs), but also case management FTEs necessary for the expansion of new services in order to fully meet all unmet need for all clients projected to be on the caseload for 2001 (132 FTEs).

**Administrative Support includes clerical, information support specialists and accountants. Ratios are: Supervisors—1: 8; Clerical support—1: 10; Plus 6 Information Support Specialists and 6 Accountants]

The results of the projections for the increase from 1997 to 2001, show that:

- filling the 1997 existing need requires 198 case/resource manager FTEs and 56 supervisor and administrative support staff.
- 56 more case/resource manager FTEs and 13 supervisor and administrative/support staff FTEs are needed to deal with the anticipated caseload growth at a cost of $4.6 million.
- the overall annual cost to fill the existing 1997 need, plus the projected 1997-2001 need, for FTEs is $21.7 million, which includes an overall FTE increase of 324.

If these FTE increases were funded, the number of clients per case/resource manager in 2001 would be 60.

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